

# A Caring State for All Older People?

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The Nordic Welfare states are frequently designated with labels like ‘social service states’ (Anttonen 1990) or ‘caring states’ (Leira 1994 ) as they offer a wide variety of services, including care services for children and elderly, to citizens of all socioeconomic groups. In this chapter, attention will be directed toward the Nordic home care service, a service which is often regarded an icon of the caring states. Home care is neither the most comprehensive or costly part of Nordic elder care, but we believe that this service institution may serve as an illuminating case to display some of the preconditions of and challenges confronting the Nordic universalist welfare policy.

The aim of our paper is twofold. Firstly to explore to what extent the Nordic countries tend to have departed from the core idea(s) of universalism. Secondly to identify some driving forces behind and consequences of ongoing changes. Concerning the latter aim we will take into consideration the particular multi level governance of Nordic welfare policy, which have been described as ‘local authority-driven welfare society models’ (Kröger 1997). As municipalities play a central role both in financing and administering welfare benefits their autonomous role of local authorities, in particular their authority to prioritize among political issues and to make their own organizational arrangements, bring about considerable local variations in service provision (Trydegård 2000).<sup>1</sup>

The paper describes the development of the Nordic home care services in light of a typical Nordic reform trajectory and continues to elaborate the case of Sweden in order to grasp some core mechanisms of change which again may be regarded as driving forces away from a universal all-inclusive welfare model.

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<sup>1</sup> Local variations make it particularly difficult to trace any clear-cut trends in the way municipalities operate. Ongoing changes will often be patchy and creeping and will appear as adjustments rather than “real” policy changes. Moreover, changes are complex and characterized by tensions and pulls between different logics of governance (Vabø 2009).

## **Notes on the concept of universalism**

Universalism is a multi-dimensional and complex concept which has been contested throughout much of its history (Kildal and Kuhnle 2005). However, many disputes seem to take their point of departure in rather oversimplified views on universalism. We agree with Thompson and Hogget (1996:27) who maintain that a conception of universalism as equivalent to procedural impartiality reflects a crude form of universalism as it tends to confuse impartiality with uniformity and equality of treatment with sameness of treatment. It is not difficult to disagree with those who believe that treating people as homogenous may reinforce existing inequalities in the population. However, universalism in social policy is not basically about procedural impartiality. We believe it is more specific about protecting (and extending) social rights based on citizenship. Even Titmuss, one of the pioneers of mainstream universalism in social policy, recognized the need to allow for some selectivism. Titmuss distinguished between negative and positive selectivism. He rejected *negative selectivism* - the targeting of services on individual means (Titmuss 1976). However he did advocate *positive selectivism*, which aims to provide additional services and resources for certain disadvantaged groups. Titmuss argued that different standards were appropriate in different circumstances for different individuals and groups. In a Nordic context the distinction between positive and negative selectivism is often expressed through the principle that services are *needs tested* rather than *means tested*.

More recent debates on universalism do not primarily concern the question of selectivism but rather question of particularism. Universal welfare systems are accused of being unable to handle and respond to an increasingly diverse citizenship and population. Again we want to dispute the underlying assumption that uniformity is an absolute condition of universalism. We believe that a stress on uniformity and sameness may be associated with highly bureaucratized forms of service delivery, but a bureaucratized form of service delivery is not the only conceivable form of welfare organization. According to Thompson and Hogget (1996) the confusion between universalism and uniformity is linked to the fact that in the UK universalism has been strongly associated with the centralizing and bureaucratic Fabian welfare state. Postmodern, feminist and communitarian critiques of universalism tend to attack the clumsiness and inefficiency of welfare delivery since it is too distant from recipient of welfare. According to the authors their critique is directed at the institutionalized expression of social rights rather than at the existence of these rights per se. (Thompson and Hogget 1996).

The fact that universal policies are being implemented through bureaucratic institutions does not rule out the possibility that universal policies may be implemented through less bureaucratic arrangements. Firstly we will argue that equality and diversity refer to values at different levels of abstractions: 'Universalism' is deliberately abstracted from differences between persons and groups in order to treat them fairly while 'diversity' refers to a concrete level and aims to capture what is unique and particular for individuals and groups. People are both *different* and equal – just like apples and pears. Apples and pears represent different flavors and shapes (they are different), but are still both fruits (equal). Secondly, we will maintain that attention to the uniqueness of individuals may be encouraged through professional work cultures, even though these cultures are embedded in a universal welfare system. It remains possible for front-line staff to both be committed to the principle of equal access and still be sensitive to diversity of citizens. Reflective practitioner regarding every human being as 'a universe of one' (Schön 1983) may play a key role in making the principle of inclusive and equal citizenship come true.

In the field of care research the key concept of 'rationality of caring' (Wærness 1984) can be related to and helpful for thinking about how universalism and diversity might be made

meaningful in policy, organization and practice in elder care. The term ‘was coined to highlights the logic of looking after the concrete and shifting needs of individual care recipients. ‘Rationality of caring’ underscores that good care is more than being attentive to wants, preferences and prefixed agreements; it also implies attention to the incapacity of the dependent person and attention to the situation here and now including sudden shifts in needs. Wærness and Gough (1985) note that this particular rationality of caring is in constant tension with the logic of justice which highlight detachment, impersonal rules and procedural justice. Hence, in order to enhance trust and create legitimize “from below (Rothstein 2007) home care providers will need a minimum latitude to pursue reliability and to adapt to instable and shifting needs of individual care recipients (Vabø 2009).

Universalism can and should incorporate both positive selectivism and particularism. In line with Thompson and Hogget (1996:34) we believe that universalism and particularism represent a mutually reinforcing duality. Universalism seeks to provide a fair standard by which to treat particular cases. To ensure genuine equality, people who are different may need to be treated differently (Lipsky 1980). Particularism derives its moral standard from an underlying universalism – the idea that differences should be equally respected. Efforts to grasp the essence of the universal welfare model ( ref) often emphasize that public services are not just *accessible* for everyone, but *actually used* by everyone. In line with Clark (2004) we may say that mere accessibility reflect a liberal or passive form of access policy; people are given “a door to knock” on – if people do not put themselves forward it is their own choice. In order to ensure that services are actually being used by everyone on could, to put it crude, either try to motivate or change people or try to accommodate institutions to different people. As an access policy aiming at changing people to fit with the existing service provision may produce strained and ill-fitting social relationships, we believe that the challenges confronting the universal welfare policy is basically about creating institutions which are able to respond to a diversity of differences (Clarke 2004).

The current debate on universalism/ particularism often refer to the problem of shaping institutions that are sensitive to the multiple demands and voices of marginalized and minoritized groups. We believe that this challenge is of increasing importance also in the Nordic countries as our countries are becoming increasingly pluralized. However, in a Nordic context, the question of whether services are actually used by everyone also link to the question whether welfare institutions are able keep up with the quality demands of the upper middle class. Will tax funded welfare provision, like home care, be able to satisfy the discriminating taste of the upper middle class? One idea behind Nordic universalism is that standards should be sufficiently high to discourage the demand for supplemental private solutions ( Erikson et al 1987). If most people have a stake in a universal service program they will also support the system. As soon as services deteriorate and people start looking for private alternatives, a process of creeping negative selectivisation may be triggered.

### ***Institutional changes***

To comply with our conceptual discussion we will take as our point of departure that universalism in human service provision is based on the presumption that services are perceived as trustworthy and inclusive by all groups of citizens. In order to come as close as possible to this ideal of inclusion, services will seek to adapt to peoples’ variable health and life circumstances and to their different tastes, moral standards and values. To what extent do the modern home care services live up to these ideals? Do we see any institutional changes affecting their ability to adapt to complex and diverse needs? Or do we see any changes affecting their ability to tailor services to peoples’ diverse lifestyles?

Public debate concerning the adaptability and responsiveness of home care is often confined to a question of free choice of care provider. It is argued that older people should not have resort only to a monopoly provider, but should be given the option to choose from a menu of care providers. The debate is based on a consumerist discourse which is appealing as it takes the side of the individual against powerful bureaucracies and freedom of choice against compulsion and uniformity (Vabø 2006). However, the presumptions made within this discourse are rather decoupled from the particular historical/ institutional context of the Nordic home-care system. They seem to be highly influenced by the standardized narratives of change linked to the public sector modernization program circulating in many OECD countries. According to Clarke and Newman (1997:49) such standardized narratives of welfare change tend to demonize the past and idealize the future; the discontinuity between the ‘bad old days’ and the new flexible, responsive future is stressed in terms of from/to movements :

from provider dominated	to user dominated
from monopolistic	to market driven
from compulsion	to choice
from uniformity	to diversity
from a culture of dependency	to a culture of self reliance

These simplifying from/to lists involve not just an overly optimistic view of the future, but also a mis-remembering of the past. They disregard that social services, such as elder care were, and remain labour intensive and involved complex discretionary practices. We find these points made by Clarke and Newman of particular relevance for our inquiry into the process of change within Nordic home care system as the standardized consumerist narrative rather ill-fitted to the historical institutional evolution of the home care service. A comprehensive body of care research undertaken over several decades reveals an almost reverse story of change. Home care did not evolve from welfarism/uniformism towards flexibility/choice; rather the service was launched as a personal service, tailored to individual needs and has since then been pushed in more homogenized direction by several attempts of regulation, rationalization and ideologization.

### **The early days of home care**

Home care in Nordic countries did not originate from a top-down policy plan, but rather “from below” from national and local associations of women undertaking voluntary care and health work. Communitarian driving forces played a push role for the state to assume the economic responsibility for elderly care.

When home care became a part of the public welfare programs in the 1950s (Sweden) and 1960s (Norway), the idea of a care service being sensitive to individual needs and wants was at the forefront: The overall welfare goal was to enable older people to carry on their accustomed life as long as possible. People should not be compelled to adapt to the services of public old age homes – public services should adapt to people’s homes! The development was warmly welcomed as an individualized alternative to the existing institutions for the aged. And older people very much appreciated being relieved of the undignified experience it is to be a burden to their own children.

The development of municipal home care services implied an important policy shift. It brought about a new historical situation for frail elderly who could now choose between receiving help from their close kin or from the public system. They could choose to stay in their own home even with increasing care needs, instead of being forced to move either to

their children or to an old age home. In practice it also implied a 'freedom of choice' for their middle-aged daughters who could choose gainful employment despite an ailing parent (Szebehely 1998).

Looking back on the earliest phase of the home care services, the preconditions for delivering a customized service were prominent. Home-helpers were based in their own homes and were paid by the hour to help a few clients. It was up to the service provider and service recipient to come to an agreement on the essential service elements or tasks that were to be provided within the allotted time. The early home-helper's occupation has been described as a new variation of the traditional woman's role, wherein the needs of others determined the type of work to be performed and 'extra rewards' were achieved when the dependent person expressed gratitude and affection (Lingsom 1997).

As it took time for this non-family home care to be recognized socially, the traditional home care service was perhaps not universalistic in the sense that it was actually used by everyone. However, as state funding was generous and as it in fact incentivated municipalities to expand their home care provision, services were available for those who asked for it. And home care became popular among elderly people. In Norway, the number of home care recipients was four times higher in 1980 than in 1965 (Vabø 1998). In Sweden, the growth started somewhat earlier, and between 1960 and 1980 the number of home care recipients increased from 50,000 to 250,000 (Szebehely 2005).

We consider that the rapid expansion reveals that home care was recognized in the population as a trustworthy welfare institution (Vabø 2009). Research into the traditional form of home help shows that service recipients appreciated the combination of stability (knowing who is coming each day and how long the home helper will stay) and the opportunity to affect the content and implementation of the help (Szebehely 1995).

### **Radical decentralization and professionalization**

From the late 1970s an era of expansion gave way to an era of stagnation and consolidation. Home care gradually became more organized, regulated and rationalized as all the Nordic countries entered a trajectory of reforms characterized by radical decentralization of politics and administration (Premfors 1998). Legislative changes delegated to municipalities the responsibility for a wide range of services with the aim of encouraging an integrated approach to the delivery of care. Municipalities were required by law to organize certain kinds of care services including home care and residential care. People in need of care were given certain *procedural rights* relating to decisions about allocation of service. They were given the right to an individual needs assessment, to receive a written and well-founded decision and to make a complaint against it. Despite the legal right to be assessed for home care, municipalities have a considerable degree of local autonomy in how they assess needs and how they choose to deliver care.

When the responsibility for home care was decentralized to the municipal level, the service was typically organized in a network of service groups, each group sharing the responsibility for a certain geographical district. The decentralized group structure reflected a belief that care needs were complex and shifting and those closest to the service recipient should conduct needs testing and allocation of service. As home-helpers were organized in self-regulated care groups, they became more professional and their former discretionary freedom was, to some extent, replaced by common agreements, working rules, and care ideologies of the working group (Eliasson Lappalainen & Motevasel 1997). One core working principle of the home care service was 'giving help to self-help'. The professional home care staff would encourage and activate people to utilize their own coping resources. Ironically, this ideology of

activation occurred at a time when the average service recipient was older and more infirm than was the average recipient of the earliest home help service (Vabø 2006).

The formalization of service allocation (i.e. the formal procedural requirements required by the law) and the more professional “people-processing” view on care recipient reflected a certain turn away from the caring values of the traditional home care service. Nordic care research recognized emerging tensions in home care and questioned to what extent conditions for good care work were being undermined. For instance the increasing stress on procedural rights (a professional ideology of activation) have the potential to undermine the logic of caring for instance if older people are encouraged to carry out tasks which they have never performed in their ‘accustomed’ life (Vabø 1998). Eliasson (1995) suggest that good practical care work is a balancing act between two ethical considerations – taking responsibility for the other and having respect for the integrity of the other. If either of these ethical considerations is disregarded, care may degenerate either to paternalism or the sin of omission. This may happen if care providers are too blinded by procedural justice, work ideology or simply by lack of attention due to tight time schedules.

### **Contractualization and transparency**

In the 1990s a further push towards more transparent and predictable care services was generated by a stream of reforms, influenced by new institutional economics and business-style of management – referred to as ‘New Public Management’ (NPM). Being influenced by an enterprise discourse local home care departments put increasingly weight on “advertisements” and citizen charters – people should be well-informed consumers. The fundamental, structural principle linked to these reforms was the purchaser-provider split. The model was regarded a basic condition for the local authorities to make quality demands and subsequently to control and manage quality at arm’s length. The idea was that the public care authority should tender and purchase services on behalf of the public, and the provider could be either a private agency or a public sector agency. In this model the responsibility for the initial needs assessments in home care was removed from the care teams and put in the hands of a specialized care assessors who assess individual needs, specify contracts, order services and control outcomes. It was presumed that specifications, citizen charters and contracts based on a detached need assessment should make services more predictable and strengthen the legal security for individual service recipients (Blomberg 2004, Vabø 2007).

It may be argued that the new stream of reforms increased the accessibility of home care as the service now were put in the limelight through “advertisements”, citizen charters and information on the web site of local authorities. The fact that people were made more aware of their own entitlements obviously has raised the demand for services, at least in some municipalities (Vabø 2009). Still it remains possible that the gate keeping of specialized care assessors may have been stricter than was the previous leaders of home care groups. It has been questioned whether the care assessors really act as the guardians of legal protection or whether they are conquered by an overarching concern about cost control. A survey among Swedish municipalities indicates that needs assessments have become stricter in municipalities that have introduced a purchaser- provider model (Socialstyrelsen 2000).

Inquiries into the routines of care assessors suggest that purchaser units do not always follow the law in the sense that they base decisions on legally valued argumentation – rather they follow the letter of local guidelines (Norman & Schön 2005). In line with our theoretical discussion made earlier, it may also be questioned to what extent services were made more inclusive and entrusting as the staff-client relationship were supposed to be guided by formal agreements and citizen charters. Several research reports suggest that the latitude of care staff to act flexibly and to show humane considerations was endangered. Deviations from contracts

were supposed to be negotiated with and approved by the purchaser unit and the process was perceived to be awkward, inflexible and time consuming (Norman & Schön 2005, Norman 2007, Vabø 2006). The perceived problem may be understood as a manifestation of the tension between the rationality of caring and the rationality of justice.

### **The resilience of traditional care values**

The institutional history of home care outlined here, indicate that the structural conditions for providing individualized care have been undermined, where developments are most advanced. Nordic care staff experience less and less freedom of action and more than ever feel that their services are inadequate in view of the needs of service recipients (Szebehely 2005:398). However, it should be repeated that this trend is not equally true for all municipalities and all care districts; the perceived work pressure among care giver staff vary within all the Nordic countries (Elstad & Vabø 2007).

We will also stress that the institutional changes described here sometimes appear in rather soft versions in the sense that the traditional care values are well preserved. As noted by Eliasson Lappalainen & Motevasel (1997) the caring culture of the traditional home help service, was not fully repressed by professional cultures. Likewise we will argue that it is not being fully repressed by managerialism and market relations. In a field study carried out in four home care units in Copenhagen, Oslo, Stockholm and Helsinki we generally observed far more elastic and adaptable solutions than we traced in the official documents from the city wards (Szebehely 2003, Vabø 2003). This and several other field studies (i.e. Christensen 1998; Thorsen 1998; Lewinter 1999; Hansen *et al.* 1999; Petersen and Schmidt 2003; Rønning; 2005, Nielsen & Andersen 2006) revealed that care giver staff frequently disregard fixed routines and care assignments in order to reduce the negative consequences of inadequate conditions for care. They work against the system; they cut corners and make adjustments in order to meet the complex and shifting needs of frail individuals, but also in order to feel that they are doing something worthwhile. Home care workers continue to gain satisfaction and motivation from the relationship with the care recipients; it is important for them to provide care that the recipients are satisfied with (Trydegård 2005).

### ***Home care services for all older people? The case of Sweden in the dawn of the 21<sup>st</sup> century***

The history of the Nordic home-care services sketched out above suggests that home care started off as a truly universal, accessible, individualised public welfare service, used and appreciated by older people in all social groups – and by their families. We have argued that even though local variations occur and care workers are regularly disobedient to rules and contractual specifications, a range of realignments and financial cut-backs have made home care provision more predefined and rigid and hence less attractive from a recipients point of view. A central question is whether the publicly financed home-care service of today can live up to the idea(1) of an inclusive universalist welfare model.

In this section we take Sweden as an example and look more closely at the changes that have taken place during the last decades. The trends we will discuss are not unique for Sweden but we believe that the development towards more market oriented models of care has been more dramatic there than in the other Nordic countries. We will argue that in Sweden a contraction of tax financed eldercare has been followed by an offloading both to services purchased at the market and paid out of pocket (*marketisation*) and to unpaid family care (*informalisation*). Within the publicly financed and regulated services there has been a shift towards more *competition* between public and private providers in the form of out-sourcing or customer choice models (vouchers). Finally, there has been a shift towards *privatisation of financing*: a

shift in how the cost for the publicly regulated services is shared between the service users and tax payers.

We summarise these trends as *different forms of privatisation* and we will discuss to what extent the Swedish home care services still may be labelled universal. In particular we will discuss whether home care still is an attractive and accessible welfare service for all social groups or are well off groups turning their backs to the system.

### **Informalisation and marketisation: two sides of the coin of reduced tax financed care**

In Sweden (as in Finland, see Kautto 2000 and Kröger et al 2003), since the early 1990s the total expenditures on elder care in relation to the number of elderly people in the population has been clearly reduced. As a share of GDP, however, Sweden with the world's oldest population is still a generous elder care spender (OECD 2005). Scarce resources are increasingly targeted to older people with the greatest needs, while people with less extensive needs tend to be left without public support. However, elderly people with comprehensive care needs and the oldest age groups are also affected by cut-backs. Between 1980 and 2005, the share of the population 80+ who receive home care has decreased from 34 to 20 percent (Larsson & Szebehely 2006). Today the coverage of publicly financed elder care is clearly lower in Sweden than in the other Nordic countries (Nososco 2008). In terms of coverage there is no longer one Nordic model (Szebehely 2005, Rauch 2005):

The decline of elder care in Sweden is not a result of improved health among the oldest old (Thorslund et al 2004). Neither is it a result of legislative changes at the national level. Rather the decline is a result of a set of decisions at the local level. Many municipalities have met the population ageing with stricter local guidelines for needs assessment resulting in raised thresholds for entering the services. But the decline is probably partly also a result of an exit from the services by older people themselves due to the higher user fees, increased pre-regulation of care and taylorisation discussed in the previous section (Szebehely 2005).

Concerning the idea(s) of universalism question may be raised whether services still are used by all socio-economic groups. According to a large, randomized population based survey, the answer is yes: similar proportions of older people with different educational background in need of help are using tax funded home care. The reduced service coverage seems to have hit all social groups in similar ways. But there is a clearly class related pattern when it comes to how people compensate for the lack of publicly financed services, see table 1. The trend of *marketisation* – an increase of privately purchased services – concerns older people with higher education while the trend of *informalisation* concerns older people with lower education who increasingly often receive unpaid family care, both as a substitute for home care among elderly with smaller care needs and as a complement to home care for those with larger needs (Szebehely & Trydegård 2007).

Table 1. Providers of care among older people (65 years+) in need of practical help living at home. Sweden 1988-89 and 2004-5.

Receiving help from (%):	Elderly people with maximum 9 years of education		Elderly people with more than 9 years of education	
	1988-89	2004-05	1988-89	2004-05
Publicly financed home care services	47	41	44	38
Help from non-residing family member or friend	43	58	33	37
Privately purchased help	11	9	14	19

Source: Szebehely & Trydegård 2007<sup>2</sup>

Thus, even though the home care services are used to the same extent by rich and poor, the contraction of publicly financed elder care has led to a class related *dualisation of care*. As a result, the use of family care and privately purchased help in the two educational groups differ considerably more today than in the end of the 1980s.

This class related pattern of care should be related to elderly people's preferences. In Sweden, a majority prefer to receive help from the public home care service or from a spouse rather than from other family members or from the market, see table 2.

Table 2. Care preferences concerning domestic and personal help among older persons (75 years +) living at home. Sweden year 2000

Preferred carer (%)	Help with laundry or cleaning		Help with shower/bathing	
	Elderly with maximum 9 years of education	Elderly with more than 9 years of education	Elderly with maximum 9 years of education	Elderly with more than 9 years of education
Husband/spouse	28	28	27	30
Help from non-residing family member or friend	13	10	9	9
Public home care	52	46	56	47
Tax financed home care, outsourced to private providers	1	6	1	5
Privately purchased help or other help (incl. help from voluntary organisations)	2	6	1	4

Source: Szebehely & Trydegård 2007.<sup>3</sup>

Only around 10 per cent prefer to get help from a daughter, other relative or friend, and even fewer prefer to buy private help. There are no class related differences in preferences when it comes to family help. Compared to elderly people with lower education, however, elderly people with higher education do have a more positive attitude towards the market as provider of care, both within and outside the tax funded services.

A conclusion from combining table 1 and 2 is that far more elderly people in Sweden receive than prefer help from their families and that the gap between preferred and actual family help

<sup>2</sup> Own analysis by Szebehely & Trydegård of Statistics Sweden's Living Conditions Survey. Need of practical help is defined as needing help with at least one of the following tasks: cleaning, grocery shopping, laundry, cooking, bathing, getting dressed and getting up from bed. The respondents could mention several sources of help, including help from spouse which is not reported in the table. Total N=1,162.

<sup>3</sup> Own analysis by Szebehely & Trydegård of data from the National Board of Health and Welfare (N=1,285).

is much larger among older people with lower education. Thus, as the increase of family care among the less resourceful groups of elderly is against the public opinion, the offloading from public care to family care must be regarded a *coerced informalisation* of care.

The offloading to family care is not only unwanted from the perspective of elderly people themselves. It is also in contradiction with Nordic family legislation and elder care policies stating that it is the municipality – not children or other family members – that is responsible for providing care for elderly people.

According to the idea(l) of the universal welfare model the welfare state is supposed to protect the citizens from being entirely dependent on their families. The concept of de-familisation has been used to capture this aspect of the universal welfare model (Lister 1995, Leitner 2003). In Esping-Andersen's words (1999, p. 51): "A de-familializing regime is one which seeks to unburden the household and diminish individuals' welfare dependence on kinship". The offloading of elder care to family in Sweden may thus be seen as a class related *re-familialisation*.

The reluctance to receiving care from family members is not unique for Sweden or other Nordic countries. Daatland & Herlofson (2003, p. 556) conclude on the basis from a five country comparison:

"When alternatives are available, today's older people seem more reluctant to receive help from the family than are adult children willing to provide such help, and the young are more inclined towards family care provision than the old."

But even if adult children in general seem to be willing to provide care, the contraction of the public responsibility has led to an uneven distribution of consequences for the family members. Family members of frail elderly people from lower social classes are providing increasingly more help. This raises the issue of informalisation in relation to universalism not only from a class but also from a gender perspective: it is in particular elderly people's middle aged daughters and other female relatives who have increased their help (Johansson et al 2003). The pressure to care for elderly parents has become harder on working class daughters.

The class related informalisation and re-familialisation of care has probably not only made older people more dependent on their families. Also women – and men – on the other side of the caring relationship are affected.

There is very limited research in the Nordic countries on the interface between care responsibilities and gainful employment (Kröger 2005), but it is obvious that also in Sweden do women see their relation to the labour market affected by a caring responsibility: 4-5 per cent of women and 1-2 per cent of men aged 55-74 years have either shortened their working hours or left the labour market entirely in order to care for a family member. Only a small fraction of these carers have received financial support for their caring efforts. At the same time as the number of family carers has increased, the number of carers who are employed as family carers or who receive care allowances has declined (Szebehely 2006).

Labour market participation among middle aged women is higher in Sweden (and Iceland) than in most other countries (Eurostat 2008). A combination of a caring responsibility for an older parent and gainful employment may thus be at least as common in the Nordic countries than elsewhere. Therefore it is surprising that much more attention has been paid to 'working carers' and 'juggling work and care' in the Anglo-Saxon countries (Phillips et al 2002). As Kröger (2005, p. 275) has noted: "there is a remarkable knowledge gap concerning the conciliation of work and family care for older people" in the Nordic countries. One of the few exceptions is a Norwegian study showing that seven out of ten middle aged daughters and sons

are working at the same time as they provide regular help to their parents. More than half of them report smaller or bigger problems in combining care and paid work (Gautun 2008).

It should be stressed that there are no proponents for increased family care in Sweden. Instead, informalisation seems to be an unintended consequence of unrealistic expectations that market services would compensate the contraction of the tax based services for all social groups.

Such a view is surprisingly naive. As Sunesson et al (1998, p. 22) argued in a critique of early tendencies of selectivisation of the Swedish welfare state:

“Selective welfare systems always carry with them the opportunity for some people to replace lacking public welfare with welfare arrangements obtained on the market. Families that cannot afford to buy personal social services will have to provide them themselves.”

More recently state money is used for supporting the replacement of public welfare with market solutions and thus supporting the tendency of marketisation shown in table 1. In 2007, the Swedish right-centre government introduced a new piece of legislation on *tax deductions for household services*. This legislative change made it possible to spend up to SEK 100,000 per year on domestic help or personal care for one self or for an elderly parent and get 50 per cent back in a tax deduction.

The first statistics on the use of this tax deduction during the first half year shows that less than one per cent of the population had claimed the tax deduction. However, tax authorities (Skatteverket) as well as the private companies offering domestic services calculate that already the following year far more people have made use of these state-subsidised services. The tax deduction was used most often among older people, but in all age groups there is a strong correlation between income and claiming the tax deduction. Very few low income elderly people claimed the tax deduction compared to five per cent among elderly with a yearly income of SEK 500 000 or more.<sup>4</sup> This indicate that daughters and other relatives of less resourceful elderly people probably do not gain from the reform. Rather the class related trend of marketisation (see table 1) may become even more manifest.

### **Competition within the tax financed home care services: outsourcing and customer choice models**

In Sweden as in the other Nordic countries, legislative changes in the early 1990s made it possible for the local authorities to enter contracts with private providers, non-profit as well as for-profit. It was argued that competition would bring about creative entrepreneurship, encourage voluntary organisations, revitalize the field and lead to increased efficiency and quality of care. To start with, *outsourcing* was the most common form of competition between providers, but more recently *customer choice models* are implemented on a broad scale (Gustafsson & Szebehely 2009).

Since the early 1990s there has been a sharp increase of private, for-profit providers in tax funded care services in Sweden. Compared to many countries, however, the private sector involvement in elder care is still comparatively small. The regular Swedish statistics on the use of services report only public and non-public (often called ‘alternative’) provision and does not distinguish between non-profit and profit-seeking providers. It is only possible to identify this distinction in employment statistics. In 1993, 0.7 per cent of the staff working in tax financed care services for older or disabled persons were employed in a for-profit

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<sup>4</sup> The authors’ own calculations from <http://www.ssd.scb.se/databaser/makro/Produkt.asp?produktid=HE0107>

company and slightly less than 2 per cent worked in a non-profit organisation. In 2000, the proportion working in non-profit organisations was mainly unchanged, while 10 percent worked in for-profit companies, mostly in large international concerns (Trydegård 2003). Thus the introduction of competition in tax funded elder care did not increase the role of voluntary, non-profit organisation. Instead there has been a trend towards *corporatisation*: the largest private companies are today own by international private equity firms and the ownership changes rapidly.

In 2008, 16 per cent of the publicly financed home care hours for older people were provided by non-public providers; an increase from 12 per cent the previous year. Despite this very rapid increase of private provision, there are still huge local variations: in three quarter of the Swedish municipalities there are only public providers of the tax funded home care services. In contrast, in some of the municipalities in the Stockholm area more than half of the publicly financed home care services is provided by private providers (Socialstyrelsen 2009a).

In 2008, the Swedish parliament passed another market oriented piece of legislation, the act on free choice systems (LOV, Lag om valfrihetssystem). In the beginning of the 1990s a couple of municipalities around Stockholm had introduced a free choice or voucher system in home care; in 2007 the model was introduced in 10 per cent of the municipalities (Ministry of Health and Social Affairs 2007a). The aim of the new law is to facilitate the introduction of customer choice models in care and with the same aim state subsidies were also offered to municipalities. More than 60 per cent of the municipalities have applied for the subsidies and intend to introduce customer choice model or develop their already existing models (Socialstyrelsen 2008).

The Swedish government hopes that the increase of private provision will continue in an even faster pace as a result of the new legislation. So does the Swedish employers organisation, Vårdföretagarna, which covers the employers of 50 000 employees in the private health and social care sector. The organisation has set a goal to increase their share of the tax financed care market to 25 per cent in 2012 and to 50 per cent in the longer term.

([www.vardforetagarna.se](http://www.vardforetagarna.se)). Even if such a goal may be an unrealistic vision articulated by an interest group, it suggests that the organisation is very optimistic about the future for private care in Sweden. The fact the three largest private care companies (Attendo Care, Carema and Aleris) recently have been bought up by different private equity firms points in the same direction: the market expects a growing arena for private care services in Sweden (Stolt & Jansson 2006).

So far no systematic differences between private and public providers of the publicly financed elder care services have been shown; neither regarding the working conditions for the care workers (Gustafsson & Szebehely 2009), nor the quality of care (Vabø 2005). Most studies were conducted before the recent increase of customer choice and refer to outsourcing. Very few studies have analysed the consequences of customer choice models.

An evaluation study of the 'free choice' program in Stockholm (which started in 2002) reveals that home care recipients appreciated the idea that they were given the possibility to choose among service providers. The option guaranteed that if they were not satisfied with the help they received, they were free to change to a different care agency. However, the same interviewees found it disappointing that the promise about 'freedom of choice' did not include the freedom of choice to make individualized agreements with the service provider (Hjalmarson 2003).

In another early evaluation report from Stockholm, representatives for the local authority and the private companies argue that the introduction of the model had increased the quality of home care services. But they also found that the public expenditures had increased due to

higher costs for administration and that also the time spent for the staff to move between users had increased (Charpentier 2004).

The most recent survey to more than 11 000 home care users in Stockholm does not support the hopes expressed by the actors in Charpentier's study on improved quality of care. The five waves of the survey since 1995 show a continuous decrease from 45 to 36 per cent of the care users reporting being 'very satisfied' with the 'general quality of the received home care'. There were no major differences in perceived quality between privately and publicly provided services and the quality had declined in a similar way in both types of organisations. The competition through a customer choice models seemingly did not improve the quality of care (USK 2009).

The survey also reports that the number of competing providers has increased and in some areas of Stockholm more than 20 providers are competing for the same 'customer'. Some of these providers have only a handful of clients (ibid). In order to compete, the providers have to offer services in a larger geographical area than previously, suggesting that increasingly more time is spent on transportation between clients.

So what about consumer choice models in relation to the idea(s) of universalism? Table 2 shows that in the year 2000, older people with higher education were somewhat more positive to private providers in tax funded home care. The study presented in table 2 was conducted before the recent expansion of customer choice models, but it may indicate that well off elderly to a higher extent than others will turn to private providers of their tax funded home care when they are given the opportunity to choose. As will be discussed in more details below, there are additional reasons to expect that a class related pattern of choice behaviour will occur within the customer choice model.

### **Privatisation of financing: raised user fees and 'topping up'**

In all the Nordic countries (except for Denmark where eldercare is still free at the point of delivery) user fees for home care are related to the amount of help provided and the individual's income. In general, there is a trend towards raised user fees: a *privatisation of financing*. In an international comparison, the private share of the entire costs for elder care services is still low in Sweden: 5-6 per cent (Socialstyrelsen 2007).

In Sweden, after a decade of increasing fees and studies showing that in particular older women with low pensions had to forgo home care for financial reasons, a national max-fee reform was introduced in 2002 capping the fees in home care as well as in residential care. In 2008 the maximum fee for care was SEK 1,720 per month. Persons with low incomes are exempted from paying fees and one out of five home care recipients pay no fees due to low incomes (Ministry of Health and Social Affairs 2007b).

Fees are important in relation to the accessibility and attractiveness of the services and thus to universalism. The max-fee reform in Sweden probably made home care services more accessible for all social groups. But within the framework of the max fee legislation, each municipality decides on its system of charging. Municipalities use fees rather as a device for reducing demands than a source of income. In most municipalities fees are income-graded and they are often higher for people who need only few hour help with domestic chores, such as cleaning, shopping, laundry. Hence, services are more costly (and less attractive) for older people with higher pensions and limited care needs. For some of the most well off it may actually be cheaper to purchase services at the private market, paying the cost entirely out of their own pocket. This economic incentive to refrain from home care and buy domestic help instead was reinforced as the tax deduction for household services was introduced in 2007.

For elderly with more comprehensive care needs this is hardly an option even if they are fairly well off. But for this group instead a combination of reforms has created incentives to turn to the private rather than the public providers of the tax financed home care: The private (but not the public) providers of tax financed home-care services can offer 'extra' services, such as extra cleaning, a walk, home made meals or whatever the elderly person may prefer and is willing (and capable) of paying.<sup>5</sup> With the tax deduction for household services the cost for the individual to buy these 'additional services' has been halved.

Thus the combination of customer choice models and tax deductions for household services creates an incentive for well-to-do elderly with larger care needs to choose a private provider for their tax funded home care and 'top up' with extra services from the same staff, using the state subsidised tax deduction.

The Government Bill 2008/09:29 which led to the act on free choice systems (LOV) discussed the issue of the right for private but not public providers in tax financed home care to offer 'extra services' (*tilläggstjänster*). The government concludes that the regulation will favour the private providers but does not see this as a problem. If the local authority would be allowed to offer 'extra services' this "would have negative consequences for the small enterprises, that both the free choice legislation and the legislation on tax deductions for household services instead are intended to encourage" (p. 127). The possibility for the private providers to offer 'extra services' is therefore regarded as a possibility to "increase their operation and reach a higher profitability" (p. 123).

In terms of privatisation of financing these trends suggest a shift towards more private financing, mainly affecting middle class elderly. In relation to the idea(l)s of universalism this suggest that well off groups of elderly may turn their backs either to tax financed home care entirely (if they have smaller care needs) or to the public providers of home care (if they have larger care needs). In both cases it may lead to a dualisation of care. As a result, the public home-care system may become increasingly dominated by elderly people with fewer resources.

### **Privatising trends – a flight from universalism?**

Recently the Swedish Long Term Survey, produced by the Ministry of Finance, argued that there is a need for a contraction of the public responsibility in elder care and other welfare services. The Survey discusses two options which could be labelled a horizontal and vertical contraction, respectively: "for the public sector to *completely pull out of financing an activity, which instead becomes privately financed*" and for other "*activities to be financed by taxes up to a certain level, but for households to supplement these activities by paying for services above this level*" (SOU 2008:105, p. 194; emphasis added).<sup>6</sup>

The Long Term Survey seems to take for granted that all social groups will be able to purchase services on the market to replace the welfare services which the public sector has 'completely pulled out financing'. As we have discussed previously this is very unlikely. Family care will always be an alternative for those who cannot afford to buy market services.

The Long Term Survey discusses only very briefly private financing in relation to the idea(l)s of universalism. The counter argument that increased private financing would be in conflict

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<sup>5</sup> It should be stressed that according to the Social Services Act, an individual in principle can get any of these services also as needs assessed, tax funded home care. The Act assures an individual needs assessment to reach a 'reasonable standard of living' and does not specify the tasks or scope of home care. Even if local guidelines often are more stringent than the law, the individual has the right to appeal a negative decision.

<sup>6</sup> For further discussion on this issue, see Meagher & Szebehely 2009.

with the fundamental objective of equality in access to welfare services, irrespective of ability to pay, is met with the following words:

Proposals for a greater measure of fee-based financing for the public services are often met with the objection that they would lead to substantial distribution effects and are dismissed for this reason. However, there are also consequences if no measures are taken. If nothing is done to meet the increased demand, dissatisfaction with what the public sector services have to offer may increase and the legitimacy of the systems may be undermined. People may thus be less willing to pay taxes. This could, in turn, further undermine the future financing of the public welfare systems. (ibid p. 210).

Here the Long Term Survey argues that private financing and the possibility to ‘top up’ the tax financed services is a way to keep the middle class willing to pay tax. The Survey forecasts that the increased *needs* caused by population ageing will be possible to meet within the tax financed system. What is not possible to meet are increasing *demands* caused by the increased standard of living (ibid. 200). The question whether the role of the welfare services is to meet individuals’ needs or their demands is not discussed.<sup>7</sup>

The issue of resources is certainly fundamental. If public welfare services are not given sufficient resources, they cannot meet the needs of growing numbers of frail older people. If the quality of care is reduced – as a result of scarce resources or unsuitable organisational reforms – the wealthier groups in the population will look for other solutions. This may in turn reduce their willingness to contribute with their taxes to services they do not use. The British Royal Commission on Long Term Care, who visited Denmark in 1999, came to the same conclusion:

There seems to be a self-sustaining cycle of high service standards leading to a willingness to pay and so to the perpetuation and improvement of standards, in stark contrast to the more familiar problem of low service standards leading to resentment of an apparently ineffectual tax burden and to a further decline in service standards (Royal Commission 1999 p. 184)

The observation made by the British commission is important. The Nordic (more or less) universal elder care model is only sustainable if the citizens find the model worth preserving. But is it possible to preserve the model if there are separate systems of care for rich and poor?

The four privatising trends in Swedish home care services that we have discussed indicate that the ‘horizontal’ and ‘vertical’ contraction of the public responsibility suggested by the Long Term Survey is taking place already. Extrapolating the trends points at a dualisation of care. We can see a scenario where elderly people with fewer resources increasingly more have to rely on informal care either as the only source of support or together with tax financed, *publicly provided* care services. Well off elderly people, on the other hand, would increasingly purchase market services, both as a substitute for tax financed home care and as a complement to ‘top up’ tax financed, *privately provided* home care.

If more affluent elderly people are encouraged to leave the publicly provided home care with the elderly with fewer resources, there is a risk of a negative self-sustaining cycle of reduced quality where public sector becomes a last resort for those who do not have any other option. This may reinforce a shift towards increasingly dualised care systems with more and better services for those who can afford it and meagre basic services or family care for the rest. Such

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<sup>7</sup> It should be noted that the Swedish middle class does not seem to be dissatisfied with the present services: a recent large survey by the Swedish National Board of Health and Welfare suggests that there are no class differences in ‘customer satisfaction’ of elder care services (Socialstyrelsen 2009b).

a development would certainly constitute a radical step away from the idea(l)s of universalism.

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